

OUR LADY of the SACRED HEART SCHOOL

REQUEST for the ADMINISTRATION of MEDICATION
(PRESCRIPTION and OVER-THE-COUNTER)

School policy requires consent of the parent/legal guardian and written statement from the licensed prescriber before school personnel can give any prescribed or over-the-counter medication to a student. Please complete this form and return it to the school office.

NAME of STUDENT _____ DATE of BIRTH _____ HOMEROOM _____

ADDRESS _____ CITY _____ ZIP _____ PHONE _____

ALLERGIES _____

TO BE COMPLETED by LICENSED PRESCRIBER

Name of medication _____ Dose _____ Route _____

Condition for which medication is to be administered _____

Time or indication for administration _____

Specific instructions for administration _____

Special conditions for storage of drug _____

Possible side effects to be noted/reported _____

Effective Date _____ Expiration date of this request _____

For ASTHMA INHALERS, EPI-PENS, INSULIN: In my opinion, this student shows the ability to administer and be responsible for carrying and self-administering the above medication YES _____ NO _____

Instructions to follow in the event medication does not produce expected relief _____

Adverse reactions that should be reported to the physician _____

Adverse reactions for unauthorized user _____

Licensed Prescriber Signature

Printed Name of Licensed Prescriber

Date _____

Prescriber's Phone Number _____

Prescriber's Emergency Phone Number _____

TO BE COMPLETED by PARENT/GUARDIAN

I give permission for the Principal or his/her designee to administer the medication as prescribed above to my child and further agree to the following:

- I will submit to school personnel a revised statement, signed by the licensed prescriber of the above, when any change in the original statement occurs.
- I will submit to school personnel a written statement when medication has been discontinued.
- I grant permission for the school nurse or his/her designee to confer with the above licensed prescriber regarding my child's health and treatment issues as they pertain to the above medication/diagnosis and his/her educational and behavioral management needs.
- I will cooperate with school personnel in assisting my child to comply with medication administration instructions.
- I understand that I must deliver all medications to school in the original container. I further understand that no medication (with the exception of asthma inhalers, Epi-pens, or insulin accompanied by prescriber's permission given above and my permission given below) is to be in possession of my child. (Cough drops are permitted to be brought to school by the child with a parental permission slip and are to be given to the homeroom teacher for disbursement.)
- I agree not to file or make any claim against anyone for negligence in connection with the administration or non-administration of any medicines and further agree to save such individuals and hold them harmless from any liability incurred as a result of the administration or non-administration of any medicines.

Parent/Guardian Signature _____ Date _____ Daytime Phone Number _____

For ASTHMA INHALERS, EPI-PENS, INSULIN: It is my opinion that my child understands the use of this medication, demonstrates proper administration, and has shown responsible behavior when it comes to carrying this medication. I further understand that my child will demonstrate proper administration and sign below stating he/she will be responsible for the medication during school. YES _____ NO _____

Parent/Guardian Signature _____ Student Signature _____ Date _____

THIS PERMISSION FORM EXPIRES AT THE END OF THE 2004-05 SCHOOL YEAR.